## Armadale Older Adult Mental Health Service – Referral Form

Email: AHS.OlderAdultCommunityReferral@health.wa.gov.au

Phone: (08) 9391 2400 Fax: (08) 9391 2429

Post: PO Box 460 ARMADALE WA 6992

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| **Doctor/Referring Agency details** |
| Name: Click or tap here to enter text. | Telephone: Click or tap here to enter text. |
| Address: Click or tap here to enter text.Suburb: Click or tap here to enter text.Post code: Click or tap here to enter text. | Fax: Click or tap here to enter text. |
| Is consumer aware of referral: Yes [ ]  No [ ]  |

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| **Client Details** |
| Name: Click or tap here to enter text. | Date of Birth: Click or tap to enter a date.  |
| Gender: Male [ ]  Female [ ]  Other [ ]  | Dependents: Click or tap here to enter text. |
| Address: Click or tap here to enter text.Suburb: Click or tap here to enter text.Post code: Click or tap here to enter text. | Telephone: Click or tap here to enter text.Preferred contact time: Click or tap here to enter text. |
| Ethnicity:Aboriginal/Torres Strait Islander [ ]  Other [ ]  Click or tap here to enter text. | Language/s spoken: Click or tap here to enter text.Interpreter Required: Yes [ ]  No [ ]  |
| Next of Kin/Significant other contact details:Name: Click or tap here to enter text.Relationship to the patient: Click or tap here to enter text.Telephone: Click or tap here to enter text.Address: Click or tap here to enter text.Suburb: Click or tap here to enter text.Post code: Click or tap here to enter text. | Is there an appointed Legal guardian?Yes [ ]  (please provide details) No [ ] Name: Click or tap here to enter text.Telephone: Click or tap here to enter text.Address: Click or tap here to enter text.Suburb: Click or tap here to enter text.Post code: Click or tap here to enter text. |
| Living alone: Yes [ ]  No [ ] Accommodation type:House [ ]  Nursing Home [ ]  Hostel [ ]  Retirement Village [ ]  | Current use of aids/equipment/mobility issues: Yes [ ]  (please specify) No[ ]  Click or tap here to enter text. |

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| **Level of urgency:** |  |  |
| Emergency [ ]  Call **000/**AHS Emergency Department  | Urgent [ ]  Call AMHS triage(08) 9391 2400  | Routine [ ]  Fax or Email AMHS (details above) |

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| **Reason for referral** (select all that apply)Diagnostic clarification [ ]  Opinion on diagnosis and management [ ]   |
| Medication review [ ]  Risk assessment and management [ ]   |

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| **Clinical details**Brief history: Click or tap here to enter text.  |
| Drugs and alcohol use history (including interventions): Click or tap here to enter text. |
| Allergies: Click or tap here to enter text. |
| Past medical history: Click or tap here to enter text. |
| Mental state examination: Click or tap here to enter text. |
| Risk assessment: Click or tap here to enter text. |
| Previous risk incidents (self harm, suicide attempts, harm to others, other risks): Click or tap here to enter text. |

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| **Management**Recent investigations: (Please fax a copy of all the recent investigations).Click or tap here to enter text. |
| Medication: (Please provide a list of **all** medications or fax a copy).Click or tap here to enter text.  |
| MH Care Plan: Completed [ ]  Not yet completed [ ]  |

Click here to email
referral form to AMHS